

Metropolitan Therapies Ltd

Patient Questionnaire



Name: _____ Date: ____/____/____
Date of Birth: ____/____/____ Age: ____ Gender: M F Marital status: S M D W
Height: _____ Weight: *Currently:* _____ *Past Maximum:* _____ When? _____
Address _____ City _____ State _____ Zip _____
Home Phone _____ Business Phone _____ Mobile/Other _____
Email address _____ Occupation _____
Emergency Contact _____ Relationship _____ Phone _____
Referred by _____
Medical Doctor _____ Address _____

What brought you here today?

When did you first notice any problems related to what brought you here and what symptoms were they?

What has happened since you first noticed symptoms up until today?

What previous medical workups, diagnosis and treatment have you had for this problem? Have these been helpful or not?

Is there anything that makes it worse? Anything that makes it better?

Please list any allergies to drugs or medications

What medications or supplements are you currently taking?

Medication	Dose	How long you have been taking it

Significant Illnesses (check all that apply)

Arthritis	Heart Disease	Thyroid Disease
Asthma	Hepatitis	Venereal Disease
Autoimmune Disease	Hypertension	Stroke
AIDS/HIV	Kidney Stones	Multiple Sclerosis
Cancer	Rheumatic Fever	Tuberculosis
Diabetes	Seizures	

Other Illnesses

Year	Illness	Treatment/Medications	Outcome

Surgeries

Year	Surgery	Outcome

Injuries/Trauma(including emotional trauma)

Year	Injury/Trauma	Treatment	Outcome

HEALTH HISTORY

Exercise

What is your daily activity level related to your occupation?

- Sedentary, i.e. mostly sitting Somewhat active Moderately active
Very active (moving around or up most of the time) Heavy duty (lifting, moving things, etc.)

What kind of exercise/physical activity do you participate in? How often per week and how long each time?

Diet

What do you typically eat for the following:

Breakfast _____

Lunch _____

Dinner _____

Snacks _____

How much water do you drink per day? _____

How many caffeinated products do you drink per day? _____

Please check any of the following that pertain to you:

Vegetarian	Artificial sweeteners	Extreme thirst
Vegan	Spicy	Thirst with no desire to drink
Raw foods diet	Sweet	Fried foods
Low fat diet	Sour	Red meat
High protein/low carb	Salty	Overweight
Dairy milk/cheese	Fast food	Underweight
Salads	Cold drinks	Normal weight for height
Eggs	Hot drinks	Very overweight

Please check any condition or symptom that you presently have or have had in the past

Digestion/Appetite

Bloating
Belching
Gas
Poor appetite
Extreme appetite
Cravings
Dieting
Tired after meals
Bulimia
Anorexia
Irritable or tired between meals
(low blood sugar)
Stomachache
Nausea
Vomiting
Vomiting blood
Heartburn/reflux
Ulcers

Intestinal

Diarrhea/loose stool
Constipation
Bloody stool
Mucous in stool
Anal fissures
Anal itching/burning
Hemorrhoids
Laxative use
Abdominal pain/cramps
Incomplete evacuation
IBS
Colitis
Gout
Chron's Disease
Gallstones
Celiac Disease

Cardiovascular/Respiratory

Chest pain
Heart valve abnormality

Blood clots
High blood pressure
Low blood pressure
High cholesterol
Irregular heart beat
Poor circulation
Swelling of ankles
Varicose veins
Heart palpitations
Pacemaker
Difficulty breathing
Asthma
Wheezing
Dry cough
Productive cough
Shortness of breath
Recurrent bronchitis

Head/Neck

Headaches
Dry eyes
Tearing eyes
Spotted vision
Blurred vision
Double vision
Corrected vision
Eye strain/tiredness
Night blindness
Red eyes
Sensitivity to light
Eye itchiness
Cataracts
Macular degeneration
Bleeding gums
Dry mouth
Excessive saliva
Sores on tongue or mouth
Hoarseness
Recurrent sore throat
Swollen glands
Difficulty swallowing

Seasonal allergies
Chronic colds
Sinus congestion/pressure
Sinus infections
Nasal discharge
Post nasal drip
Nosebleeds
Loss of smell
Earaches
Ear ringing
Hearing loss
TMJ

Skin/Hair

Thick skin
Thin skin
Broken blood vessels
Blood not clotting
Bruise easily
Skin discoloration
Bags under eyes
Lumps underarm
Dry skin
Acne
Brittle nails
Premature grey hair
Dry, brittle hair
Hair falling out
Eczema
Psoriasis
Fungal Infections
Rashes/hives

Sleep

Fall asleep easily
Lie in bed with eyes open
Wake repeatedly
Wake at specific times
Wake to urinate
Wake not feeling rested

Vivid dreams
Nightmares
Use drugs/supplements to fall asleep

Genitourinary

Dark urine
Poor bladder control
Blood in urine
Cloudy urine
Burning urination
Scanty urine
Incomplete urination/retention
Profuse urine
Frequent urination
Dilute urine
Urgency to urinate
Wake to urinate
Kidney stones
Bladder infections
Decreased sexual desire
Sexually transmitted disease

Musculoskeletal

Muscle pain
Muscle weakness
Muscle spasms
Spinal pain
Low back pain
Middle back pain
Upper back pain
Pain goes down legs
Neck pain
Knee pain
Shoulder pain
Other pain
Where _____
Numbness
Where _____
Carpal tunnel
Osteoporosis
Broken bones
Difficulty walking
Tendonitis
Swelling
Arthritis
Limited range of motion
Disc degeneration
Pain all over

Neurological

Fainting
Seizures
Tremors
Convulsions
Vertigo
Dizziness
Loss of balance
Stroke
Paralysis

Emotional

Anxiety

Irritability
Depression
Nervousness
Excess joy
Job stress
Family stress
Death of someone close
Recent divorce
Seasonal mood disorder
Often angry
Cry easily
Fearful
Easily stressed
Currently in therapy

Energy/Temperature

Low energy
Fatigue
Fever
Chills
Excessive thirst
Spontaneous sweat
Night sweating
Lack of sweating

Men Only

Enlarged prostate
Prostate cancer
Genital pain
Genital sores
Impotence
Lump in testicle
Nocturnal emission
Weak urinary stream
Penis discharge

Women only

Abnormal pap smear
Endometriosis
PCOS
Breast lumps
Contraceptive use
Sores on genitalia
Vaginal discharge
Yeast infections
Herpes
Human Papilloma Virus
Menopausal
Uterine prolapse
Facial hair
Pregnant
Live birth(s)
Miscarriage(s)
Abortion(s)

Symptoms associated with period

Breast tenderness
Irritability
Pain before/during
Headaches
Constipation/diarrhea

Pain at ovulation
Irregular periods
Bleeding between periods
No period

Age menses began _____
Age ended _____
Date of last OB/GYN
exam _____
Date of last period _____
Hysterectomy partial full
Period lasts _____ days
Usual number of days in
cycle _____

Menstrual flow:

Clotting
Dark red
Normal red
Brownish
Watery/thin
Bright red
Flooding and trickling
Stop and start flow

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